DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC accepted Administrator notified 4/18/05 B. Cavin

PRINTED: 04/01/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	C 03/23/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a complaint investigation conducted at your facility on 3/23/05. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00007469 alleged that resident eloped from the facility and that the Wanderguard alarm did not sound. The complaint was substantiated. See Tag F 309.	F 000		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, it was determined that the facility failed to ensure the safety of the resident. Findings include:	F 309	F 309 All patients have the potential to be affected by this deficient practice. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: How the facility will monitor its corrective action to ensure that the deficient practice will not recur. All admissions will be assessed for elopement risk by using Elopement Risk Assessment tool. The charge Nurses will initiate hourly surveillance form for residents that trigger. Charge Nurses will ensure that residents names with high risk for elopement are written in the daily shift assignment schedule.	Ongoing Ongoing

RECEIVED
APR 18 2005
BUREAU OF LICENSURE AND CERTIFICATION
CARSON CITY, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/15/05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 Resident #1: The resident was admitted to the facility on 9/30/02 with diagnoses of Alzheimer's disease, urinary tract infection (UTI), arteriosclerotic dementia, anemia and B-complex deficiency. Review of the record revealed that Resident #1 eloped on 3/12/05. The resident was found at the intersection of two streets of four lanes each by a couple who returned her to the facility. The resident's condition was checked by staff who found no injury and no change in level of consciousness (LOC) or range of motion (ROM). After Resident #1's elopement on 3/12/05, the updated plan of care required the resident's location to be documented every hour. A nurse at the nursing station indicated those checks were being done and that they were documented in a binder kept at the nursing station. The resident's sheet for 3/23/05 was blank. In an interview at 11:10 AM on 3/23/05, the resident's CNA stated that she filled in the sheets at the end of the day. She stated she can remember where the resident was at each hour during her shift. At 10:45 AM on 3/23/05 the nurse stated, "I don't know where she is", and asked another resident, "Is she in your room?" Approximately 10 minutes later Resident #1 was seen wheeling herself from the front hallway toward her room. In an interview with the resident at 10:55 AM, she stated she did not remember leaving the building on 3/12/05. A Wanderguard bracelet was observed on her right wrist. The maintenance supervisor stated in an interview at approximately 11:00 AM on 3/23/05	F 309	F 309 (cont) Wander Guards to will be applied to the residents right wrist to alarm staff of high risk for elopement. Unit Secretaries will ensure that batteries and wander Guards are active daily. Ongoing Orange bracets will be applied to the residents right wrist to alarm staff of high risk for elopement. 5/2/05 Sensetivity of Door sensors will be checked weekly by Maintenance Director. Ongoing Daily audit of hourly surveillance form will be done by Unit secretaries. Then Audit to be forwarded to Director of Nurses/ designee. Ongoing Staff will be inserviced on elopement. 5/2/05 The Director of Education will conduct an elopement Drill quarterly and as necessary. Ongoing Any pattern or trend identified will be assessed and evaluated with immediate corrective action. 5/2/05 4/28/05 Did not do key pad on rehab door. The door from rehab to the outside is alarmed.	

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F 309	Continued From page 2	F 309		

that he had increased the sensitivity of the Wanderguard sensors, after Resident 1's elopement. He stated that he continues to check for proper functioning of the system every Wednesday. The maintenance supervisor demonstrated the alarms were working properly by having a nurse push Resident #1 in her wheelchair through two exits, one at the front and one on the side of the facility adjacent to the rehab area. The alarms sounded immediately as the resident entered the doorway.

During a conversation with the maintenance supervisor and the Director of Nursing (DON) on 2/23/05, the elopement of another resident on 2/2/05 was discussed. The resident had left the facility through an unalarmed door to the outside via the rehabilitation area. The facility's plan of correction included installing keypad lock on the interior rehabilitation door leading into the hallway. The purpose of the keypad lock was to secure the rehabilitation room to ensure that when the room was unattended by staff, a resident could not gain access to the area and elope through the unalarmed door to the outside. The keypad had not been installed as of 3/23/05. The maintenance supervisor stated in an interview on 3/23/05, that the facility had decided the issue was not with the unalarmed rehab door, but rather with the sensitivity of the Wanderguard system. He stated he had increased the sensitivity of the sensors to ensure the alarm will sound when a resident enters any alarmed doorway, regardless of which side their bracelet is worn.

The facility failed to monitor Resident #1 in accordance with the plan of care following her elopement on 3/12/05 and and failed to alarm and/or secure all doors providing access to the

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F 309	Continued From page 3 outside in order to prevent future elopements.	F 309		